As I remember him, Doctor Bernhisel was rather a formidable person. On ordinary occasions and for professional visits he wore a long frock coat with stock collar and high silk hat, after the fashion of a doctor of the old school, which indeed he was.

He taught his children Latin, and was a stern disciplinarian. . . .

John Milton Bernhisel was born June 23, 1799, at Lloysville, Perry County, Pennsylvania; was graduated from the University of Pennsylvania April 6, 1827. He moved to Nauvoo in 1842 and died in Salt Lake City on September 28, 1881.

* * *

Medicine, like music, seems to be a family tradition and this history of early pioneer physicians in Utah would be incomplete without mention of the Richards family.

Education and close application to scientific principles are the important factors that rescue the healing art from the hands of charlatans and impostors. The history of the Richards family in Utah is one of brilliant success in the field of medicine; may a more facile pen than mine make the record of their notable achievements in the profession.

Appended below is the obituary of H. J. Richards, which gives the outline of his life and work:

Dr. Heber John Richards.—Born in Manchester, England, October 12, 1840. Parents, Dr. Willard Richards and Jennetta Richards. Father married while on a mission to England. Mother died in Nauvoo when Heber John was four years of age.

In 1848 he came to Utah with his father and the pioneers. His life was one of hardship. When but fourteen years old his father died.

Married Mary Julia Johnson April, 1862. Left for a mission to England April 30, 1863. Away three years, traveling in Europe one summer. Returned in April 1866.

November 10, 1867, left Salt Lake City for New York, being sent by Brigham Young to study surgery and carrying a letter of introduction from President Young to Dr. Lewis A. Sayer. Attended Bellevue Hospital Medical College 1867-68, 1868-69. Left New York in April 1869, arriving home in May. He was associated with, and studied under, Dr. W. F. Anderson until November, then went into the Co-operative Drug Store to study medicine and assist. Returned to New York August 1870, studying there until March 1871.

From the early Church records the following is gleaned:

Willard Richards (the father of Dr. Heber John Richards), sixth son of Joseph and Rhoda, was born in Hopkinton, Middlesex County, Massachusetts, June 24, 1804. He devoted his leisure time to the acquisition of knowledge.

In February 1827 he began lecturing on electricity and other scientific subjects throughout the New England States. For several years he devoted much time to the study of the Healing Art and delivered many instructive lectures on that subject.

In 1834 he entered the Thompsonian Infirmary in Boston and practiced under the direction and instruction of Dr. Samuel Thompson. In 1835, at the request of Mr. Albert P. Rockwood, he went to Holliston, Mass., and delivered lectures on the Botanic or Thompsonian practice of medicine, which created much excitement there and in the surrounding towns.

He removed to Holliston and practiced with success for one year, during which time he resided with Mr. Rockwood.

4476 Hortensia Street.

CLINICAL NOTES AND CASE REPORTS

CHANCRE OF FEMALE MEATUS

WITH TOTAL OCCLUSION AND NEOARSPHENAMIN STOMATITIS

REPORT OF CASE

By HERMAN FEINBERG, M. D.
San Francisco

IN presenting this case report it may be stated that it is very interesting and rare to observe an occlusion of the meatus due to a chancre and producing a retention of urine. The stomatitis following the use of neoarsphenamin is also an unusual complication.

REPORT OF CASE

A. E., a white female, age twenty-five, on June 3 complained of "knots" in both inguinal regions and dysuria. A careful history found the patient also suffering from occipital headaches and general malaise. The patient complained of these symptoms four days previous to her visit to my office.

Chancre of the Meatus.—Pelvic examination failed to reveal a lesion or inflammatory condition of the meatus, labia, fourchette, clitoris, vagina, or cervix, but there was a marked bilateral inguinal adenopathy. Smears were negative for gonorrhea. The Wassermann test (Kolmer and Craig) was negative and so was the urine. It was not possible to determine the etiologic factor producing the inguinal adenopathy, but from the above history the case was diagnosed as lues.

The patient was asked to return in five days for another Wassermann. She left town and returned on June 10 (eight days later) with a typical chancre of the meatus. While out of town the patient had to be catheterized because she had been unable to void for eighteen hours. The doctor she visited had to pass a sound and then a catheter in order to remove the urine. The same procedure had to be instituted by me to relieve her of the retention of urine. Some resistance was encountered in passing a 15-F sound through the central necrotic area of the chancre in order to enter the urethra, and then a glass catheter was inserted.

The chancre, which was markedly indurated and about the size of a penny, covered the meatal lips completely. There was a distinct and marked eversion of the urethral orifice, giving the effect of a rolled border. A darkfield examination revealed numerous *Spirocheta pallida.* The Wassermann taken at this time was four plus.

Neoarsphenamin Stomatitis.—The neoarsphenamin stomatitis deserves a few lines of discussion, as it is an unusual complication. Antiluetic treatment was administered the following day. On June 11 the patient received .45 gram neoarsphenamin intravenously. On June 13 the patient telephoned complaining of a burning, sore throat, and that she had expectorated two pieces of "black meat" which upon examination proved to be pieces of exfoliated necrotic mucosa of the hard palate. The lips, gums and pharynx were dry, hot, and markedly hyperemic, particularly the lips and gums. The lips were involved more than the gums, palate or pharynx, as they were cracked, scaly, itchy and burning. There was no general reaction. Sodium thiosulphate to the amount of .75 gram was administered intravenously and the patient noticed an improvement in her condition the following day. Another .75 gram was given on the third day. Two days later the entire mouth was normal. Citrocarbonate, Dobell's solution for a gargle, and four per cent mercurochrome as a throat swab had also been used. Neoarsphenamin was discontinued in favor of bismarsen, which the patient is receiving two-tenths gram intramuscularly twice weekly without any local or general reactions in evidence.

Stokes[1] states: "The stomatitis of mercury differs from the neoarsphenamin stomatitis in being moist, fetid, gray, membranous, and spongy. The stomatitis, associated with arsphenamin, may appear alone, in association with aplastic anemia and purpura, or with a generalized exfoliative dermatitis. The association of stomatitis with aplastic anemia following neoarsphenamin seems to be more than coincidental and to constitute a definite toxic syndrome."

In conclusion I wish to stress the point that when an inguinal adenopathy cannot be accounted for, endoscopy should be done, as evidently this particular case had a minute chancre at the urethral orifice which was the cause of the dysuria and inguinal adenopathy.

453 Flood Building.

REFERENCE

1. Stokes: Modern Clinical Syphilology, p. 309. Saunders. 1928.

STRANGULATED DIAPHRAGMATIC HERNIA IN AN INFANT

By HENRY JOHNSON, M. D.
AND
ALBERT G. BOWER, M. D.
Glendale

THE patient was a strong, apparently normal, full-term infant, born at two o'clock in the morning, of a primiparous mother by version and extraction without unusual difficulty. The nurse in charge of the infant noted immediately that when the child was placed in its crib it became somewhat dyspneic and cyanotic. When picked up and held nearly upright, these symptoms disappeared only to reappear when it was replaced in its crib.

A careful physical examination disclosed no heart lesion or other pathological condition that would account for this behavior, so it was decided to wait a few hours to see what occurred. On the morning of the following day it was decided to x-ray the chest in order to rule out any enlarged thymus. These pictures disclosed a moderately enlarged thymus, and also some

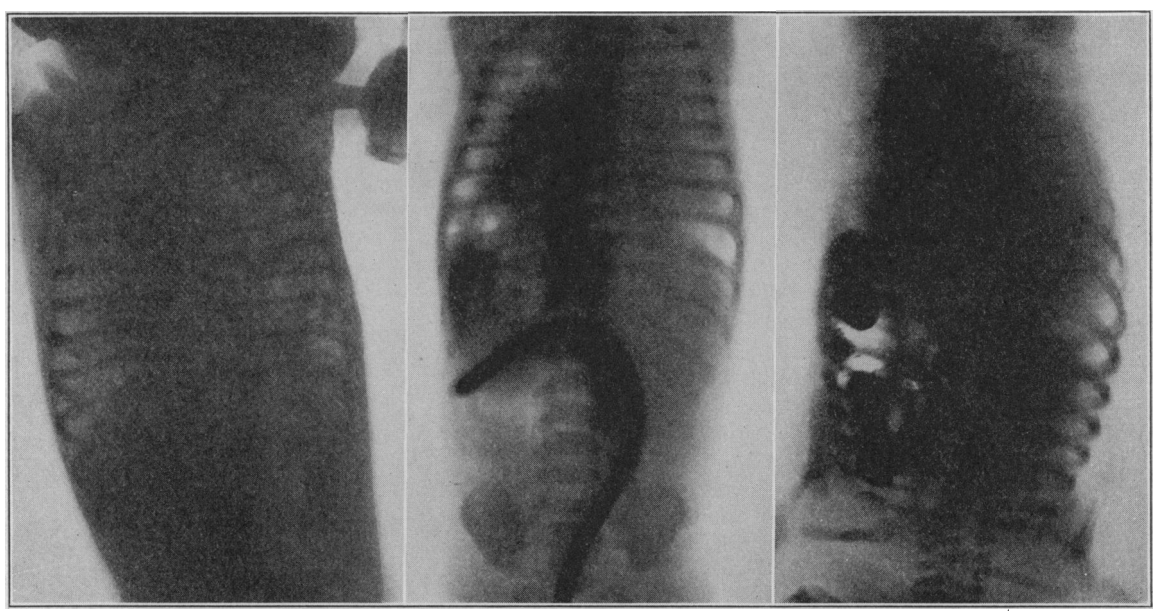

Fig. 1.—Flat plate with intestinal gas marking left side of thorax.

Fig. 2.—Catheter used to give barium enema, showing colon in pleural cavity.

Fig. 3.—Barium test-meal, showing intestines in left thoracic cavity.